VOL. 15, NO. 1 MAY-JUNE, 1965

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

What's Brewing 28

Letters to the Program 8

A Physician's Philosophy 2

Public Health Nurses Speak Up About Alcoholism 16

Should We Jail Alcoholics? 20

Latest on Over-Drinking 4

Alcoholism Revised 9

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

About the Center . . .

The A.R.C., as it has come to be known, is a 50 bed in-residence treatment facility for problem drinkers. Located at Butner, N. C., a small community approximately 12 miles north of Durham, N. C. off Highway 15, it is operated under the authority of the N. C. Department of Mental Health. The Center provides residence, treatment and workshop facilities for 38 male and 12 female patients.

A.R.C. Treatment Methods . . .

Treatment is by psychotherapy and consists of group discussions led by the professional staff, educational films, individual consultations with staff members, vocational guidance, recreation, rest, proper food and prescribed medications.

Length of Stay . . .

The basic treatment program is based on a 28-day schedule. The patient may remain for a longer period if, in the opinion of the staff, it will be of further therapeutic benefit to him. No applications for less than 28 days are accepted.

Admission Requirements . . .

1. Persons desiring admission must come voluntarily. No one can be admitted by court order. The individual who is sincere in wanting help and who comes voluntarily stands a much better chance of successful rehabilitation.

2. An appointment for admission is obtained by written or telephone application to the Admitting Officer, 406 Central Ave., Butner, N. C. (telephone 919 985-6770). All appointments are confirmed by mail. Preferably they should be made through a physician or other professional person in the prospective patient's community.

3. Since the Center is not designed, nor equipped, as a sobering up facility, the prospective patient must not have taken any alcoholic beverages for at least 72 hours prior to admission.

4. A report of a recent physical examination by a duly licensed physician must be presented prior to or at the time of admission. The prospective patient's physical condition must be reasonably good enough to enable him to participate fully in all phases of the treatment program. There are no medical beds for the treatment of serious physical or mental disorders.

5. A fee of $75 in cash or certified check only must be paid at the time of admission. No personal checks can be accepted! Cases of true indigency must present written evidence in the form of a letter from their county welfare department at the time of admission or before.

6. A social history, compiled by a trained social worker in the local welfare or family service agency or other professional organization is required. Arrangements for the history should be made early enough so that it reaches the Center within a week following admission.

Admitting Days . . .

In order to facilitate the program of treatment by the small group method, prospective patients are admitted on Wednesdays, Thursdays and Fridays from 8 to 12 a.m. and 1 to 5 p.m. In this manner several days of adjustment to the life of the Center are provided before the beginning of the intensive treatment program the following Monday.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA DEPARTMENT OF MENTAL HEALTH

NORBERT L. KELLY, Ph.D.
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UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912

The alcoholic, if not treated, will progress to a degree of illness from which chances of recovery become slim indeed.

BY W. F. CRESSWELL, JR., M.D.

A Physican's Philosophy

MEDICAL schools teach what is known about the etiology, epidemiology, signs, symptoms, course, complications and treatment of an illness. How a physician treats any illness depends upon his knowledge and understanding of the disease. This is especially true of the disease alcoholism. Dr. Ruth Fox several years ago pointed out that the full treatment of the patient with the disease alcoholism also depends to a certain extent on the therapist's own attitude toward life. Medical school faculties do not often include this bit of wisdom in their learned dissertations.

The physician must believe in the potential dignity inherent in every human being. Treating the alcoholic successfully involves teaching him to regain his self-respect without which he cannot recover. The physician must accept and believe that the alcoholic is the victim of a disease and not just weak; not just a bum, not a menace to society, not filling hospital beds needlessly but a very sick person, who, if not helped, will progress to a degree of illness from which the chances of successful recovery become slim indeed.

The physician must remember that the alcoholic often sets standards too high for attainment and as a result the pressures become realistically overwhelm-

This article is reprinted by permission of the editor from the *Melwood Farm Newsletter,* published monthly by Melwood Farm, Box 182, Olney, Maryland. Melwood Farm is a voluntary treatment facility for alcoholics of which the author, W. F. Cresswell, Jr., M.D., is a member of the board of trustees. Neither hospital nor sanitarium, Melwood Farm has a threefold program of recovery: *physical,* through wholesome food, exercise and medical care; *emotional,* through individual and group counseling; and fellowship with members of Alcoholics Anonymous. In addition, a series of lectures by the medical staff, films, tapes and open discussions make Melwood Farm much like a school.

ing and crushing, reminds Dr. Fox. When the physician remembers all the facets of the etiology of alcoholism and applies the undestanding we have of the disease process, we can see that the alcoholic's task of controlling the use of beverage alcohol is much greater than for most of us. The physician must develop empathy for the victim of the illness and in truth say, "There but for the grace of God, go I." Too often the physician labels the practicing alcoholic as weak or the victim of a self-induced illness and does not give him the attention his illness requires.

When the doctor becomes fully informed and understands alcoholism he will not meet the alcoholic patient with his usual prejudice. The physician can be more sympathetic, tolerant and supportive, as we need to be. We can be more firm and objective, as we need to be. We can be more humble in the face of all we do not understand about the alcoholic's illness.

The physician's first problem is to help restore the patient to as good physicial health as possible. Then we must help with the emotional and social problems present. Dr. Fox points out that we cannot expect the alcoholic to give up alcohol until he can at least envision a life without alcohol as better than one with it. The alcoholic must learn to live a different life, often one involving complete change. For others, such drastic measures are not necessary. During the learning process the physician can expect some relapses and he should not be more intolerant or impatient of these "slips" than he would be of a recurrence of a duodenal ulcer, ulcerative colitis or asthma.

The alcoholic's desire to get well is essential to successful therapy. The physician's own motivation for the alcoholic will not serve as the alcoholic's motivation. The desire must come from within the alcoholic. Motivation involves a change in feelings, attitudes and way of life. For the alcoholic this includes the willingness to abstain from beverage alcohol and a plan to implement it.

Physicians should be on guard that alcoholics do not repeatedly abuse the services of a doctor in regard to repeated requests for tranquilizers and sedatives, as well as short-term hospitalizations. We are all too often guilty of falling into this trap of easing a patient's immediate pain or a family's "terrible crisis." Often all we accomplish is to render the alcoholic fit physicially to resume drinking with renewed vigor and fervor after discharge.

"...'There but for the Grace of God, go I.'"

The physician should be prepared to advise the family with regard to a long-range therapeutic program directed toward recovery. He should be familiar with the resources in each community which have understanding and willingness to help the alcoholic and his family. This would include A.A., Al-Anon, family counseling services, ministers with special understanding, other physicians willing to allot the time the patient and family require and other various supportive groups. It should be remembered by both physician and patient that most successful reorganizations of a life require a minimum of two years' time. An atmosphere of faith, hope and expectancy is helpful in successful treatment.

The physician must acknowledge that successful treatment includes

(Continued on page 14)

LATEST ON OVER-DRINKING

Leading Authority Answers the Questions Social Drinkers Ask

CONTINUED FROM THE MARCH-APRIL ISSUE

From a recognized authority on alcoholism comes a guide for social drinkers—how much it is safe for a person to drink, when and how often, the danger signs of over-drinking.

Any harm in a drink or two before dinner? How about cocktails at lunchtime? Should parents worry about teen-age beer parties?

In answering these and other questions, Dr. Marvin A. Block reports the latest medical findings on drinking, and gives his own views on how a man can enjoy alcohol without running the risk of becoming a problem drinker.

Dr. Block was interviewed by staff members of "U. S. News & World Report."

Reprinted from the June 15, 1964 issue of *U. S. News & World Report,* published at Washington.

TYPES OF ALCOHOLICS—

Q Who is an alcoholic? How would you describe one?

A In order to make an adequate definition, I will try to include as many possible cases as I can, so I'll start with the very earliest manifestations of the disease.

I would say that an alcoholic is any individual who, upon drinking alcoholic beverages, has an adverse result consistent with his drinking. It makes no difference if the adverse result is a minor one—an argument with his wife—or a more serious one—loss of time from work, a fist fight, property damage, an arrest. Any adverse result stemming from a person's drinking makes that person a problem drinker. And problem drinking is actually just the forerunner of alcoholism.

Of course, one must always remember that there are many kinds of alcoholics. You can't lump them all together.

Q How many kinds are there?

A There are probably as many kinds of alcoholics as there are kinds of people. But they fall into a few general classifications.

Q Can you explain?

A The most interesting way of classifying alcoholics, and the one that I think explains alcoholism best, classifies all alcoholics according to patterns of drinking. It was developed, and the types of alcoholics delineated, by E. M. Jellinek, perhaps the greatest authority on alcoholism who ever lived.

He named the types with the letters of the Greek alphabet. They fall into five main categories.

The first one drinks for courage. He is the alpha type—the psychologically dependent alcoholic. He may need courage to ask a girl for a dance. He may need a certain amount of removal of his self-consciousness or inhibitions in order to converse freely with some one. Or he may feel that he wants to ask for a raise from his boss and somehow is a little hesitant about doing so. If he takes a drink, it gives him courage, and he

goes ahead.

Q Is this person really an alcoholic?

A It is a type of alcoholism, yes. Perhaps the mildest type, let us say—more a symptom than the disease itself, because it only is an indication of the psychological problem.

But suppose he begins to develop "tissue tolerance." Then he must increase the dose of his drug—alcohol—in order to get the effect—the courage—he wants. Then he is beginning to develop a physical dependence, and this makes it much more serious.

Q Why?

A If his drinking continues, he not only has the psychological dependence he started with, he becomes addicted to alcohol. He must have it in order to function at all. Then he's hooked.

HOW THE BODY CAN REACT—

Q What other forms does this addiction take, besides the alpha one you mentioned?

A The second type, called beta, is a very interesting one.

Here we have no psychological dependence of the sort that is present in the first type we talked about. In the beta type, we have the effect of a chemical—alcohol, the drug itself—upon the tissues of the body, without any psychological problems involved whatever. Here, for instance, we find that when some individuals drink alcohol it produces an adverse effect on the lining of the stomach, what we call a gastritis. Or it may cause a swelling of the nerve sheaths which brings about a neuritis, or, when it affects more than one nerve, a polyneuritis.

Now, these are all painful. And while alcohol may be responsible for the pain, it can also relieve it.

Q Like an anesthetic?

A It affects the brain much as ether, chloroform, nitrous oxide—any of the other anesthetic drugs—but much more slowly.

Years ago, particularly on sailing vessels, if a man were injured and had to have a leg amputated, they would ply him with whisky until he was completely anesthetized and then amputate the limb, and he wouldn't fight it.

Well, the beta alcoholic is in pain caused by alcohol, and he may continue to drink to relieve the pain.

Q When the pain is relieved, does he stop drinking?

A He may. In the first two kinds of alcoholism, the alpha and the beta we have been talking about, there may be no progression, no loss of control. They may be considered merely symptoms of some underlying physical or mental difficulty.

The danger is, though, that they often lead to the third type of alcoholism—the gamma type. This is the most common type in the U. S.

Q What is it like?

A Gamma drinkers have all the characteristic marks of alcoholism: psychological dependence, progression—they drink more and more at a time, and they drink more and more often, for less and less reason, until they lose control completely.

They develop tissue tolerance now—it takes more and more of the drug, alcohol, to produce the effect they seek. From there it is a short step to complete physical dependence—the presence of alcohol in the blood stream is actually necessary to them for their cells to function.

They are addicts. If their drug is withdrawn, they suffer withdrawal symptoms.

Q And you say many people in the U.S. are this type of alcoholic?

A There are no accurate figures, but my guess would be that 90 per cent of the alcoholics in the U.S. fall in this classification—this gamma type.

Q What other types are there?

A There are two other important classifications.

The fourth type, the delta, is a different kind of alcoholism. Here we may

Dr. Marvin A. Block, a practicing internist of Buffalo, N. Y., is vice president of the National Council on Alcoholism and served 10 years as chairman of the American Medical Association's committee on alcoholism. Internationally recognized as an authority on problem drinking and pioneer in modern methods of treatment, he has written and lectured extensively on the subject. He received his B.S. and M.D. degrees at the University of Buffalo, took graduate training in London, Paris, Berlin and Vienna.

have no psychological dependence at all, even though individuals drink alcohol over long periods of time in excessive amounts. But, through the protracted use of the drug in excess, their tissues become dependent on alcohol in order to function.

They become physically dependent. They are just as alcoholic, just as physiologically involved, as the gamma type. They get withdrawal symptoms if their drug is taken away.

In grape-growing countries, particularly in Chile and in France, wine is usually drunk instead of water. There people drink wine all their lives and are never withdrawn from it. What we have is "an absence of abstinence." And we find numbers of people who are alcoholic and aren't aware of it at all until they are removed from the drug by chance—going to the hospital, for instance. Then they may go into delirium tremens without ever having known they were alcoholics.

They may not get into the trouble over drinking that the common American alcoholic gets into, but they are just as alcoholic. They can't stop drinking.

Q You indicated that there was still another common kind of alcoholic. What is he like?

A The fifth type, epsilon, is one which is prevalent in many countries—notably Spanish-speaking and Scandinavian countries. This is the "spree" or "binge" drinker, called the "fiesta" drinker in some countries.

Here we find people who drink little, or nothing, between sprees and then go on prolonged binges of drinking which may last anywhere from three days to weeks or longer.

These people are just as alcoholic as those in the other classifications, even though they don't touch a drop between sprees. You see, they have loss of control once they do start. They keep on drinking until they get out of hand, or until they are unconscious.

WOMEN, TOO, GET DRUNK—

Q Are more men alcoholics than women are?

A Not in my opinion.

In my opinion, there are as many women alcoholics as men. Now, this has been disputed by many people in the field. But most of the statistics they quote come from clinics, and clinics are comparatively public places.

On the other hand, every single private practitioner with whom I have spoken who treats any number of alcoholics at all has agreed with the findings of my practice—that there are as many women alcoholics as men.

Of course, you know that society frowns on the alcoholic altogether, but it condemns the alcoholic woman more harsly, because she is supposed to keep up the moral standards, so to speak, of the family. So she hesitates to come forward for treatment, particularly at clinics.

It's only since education has been carried on and people have come to a greater understanding of the problem that we have begun to see more and more women.

When I first made the statement in 1952 that there were equal numbers of men and women alcoholics, the world came down around my ears. They thought I was unchivalrous. Since that time we have found the ratio of women to men has risen compared to what it was then.

WHERE PROBLEM IS WORST—

Q Is alcoholism a nationwide problem?

A Yes. Of course, it varies geographically. For instance, we find that some cities and states have greater alcoholism than others.

Q Which areas have the highest rates of alcoholism?

A Well, California, for instance. San Francisco is the most alcoholic city in the country, and has the highest percentage of alcoholism. Washington, New York and Chicago have a very high percentage. The New England states also have a high percentage.

It varies geographically, as do the patterns of drinking. For instance, drinking among youngsters is different, depending upon their geographical location and the atmosphere in which they live.

Q Different in what way?

A Suburban New York, for instance, has a very high percentage of youngsters

who have their first drink at 14, most of them with the consent of their parents.

In Racine, Wis., where another study was made, we find that the percentage of youngsters who have their first drink at 14 is a little bit lower, but still most of them with the consent of their parents.

In Kansas, on the other hand, a more rural area, we find that the percentage of those youngsters who drink that early in their lives, and even with the consent of their parents, is much lower than the other areas.

So there are some differences in the cultural environment, and so on.

Q As a rule, do you find less alcoholism in farm areas?

A Yes, the urban areas seem to be a little more conducive to alcoholic drinking. But we find this varies with countries as well as with States within a country, and cities within the States.

A great deal depends upon the culture. For instance, in those societies where drunken behavior is not tolerated, we find very little alcoholism. But in those societies where drunken behavior is tolerated, we have a great deal of alcoholism. That's why I think that our tolerance of drunken behavior is what gives the tremendous impetus to the alcoholism in our country.

Q What about economic status? It takes money to drink, doesn't it?

A Yes, it does—but when an alcoholic wants to drink, he finds methods of getting it, and it makes no difference. Alcoholism is no respecter of economic status. We have alcoholics in every stratum of society, economically speaking—from the very highest to the very lowest.

Q How do you account for the increased interest in alcoholism?

A I think the people are beginning to awaken to the fact that this is a problem which must be met, and that the more research we put into this, the greater chance of our finding a solution to this problem.

This doesn't mean that we must wait until we find the solution before we can help these people. It isn't necessary to find the cause in order to help these people, because we know that we can effect recovery with alcoholics if they will only follow through on treatment.

This means that society must accept the alcoholic as a sick person. They must not criticize him. They must not condemn him. And they must not look down upon him, because it's this stigma attached to the disease which has kept so many people from seeking help. And this is society's fault, not the individual's fault.

OVERCOMING ADDICTION—

Q You said we can now successfully treat alcoholism. Isn't total abstinence the only cure?

A As far as we know now.

We do not use the term "cure," because "cure" would imply that an alcoholic could go back to normal drinking. He can't. We call it a "recovery."

The only known way of maintaining health for the alcoholic is to stop completely, because, as with any addiction, he cannot use any of the drug to which he is addicted.

Q Dr. Block, is the view that alcoholism is a disease generally accepted now by the medical profession?

A In 1956, in Seattle, Wash., the American Medical Association, by unanimous resolution of its House of Delegates, accepted alcoholism as an illness which properly falls within the purview of medical practice, and urged all physicians to treat such patients and all general hospitals to admit them with that diagnosis.

In 1957, the American Hospital Association passed a similar resolution unanimously.

This is the only time that a medical organization, the largest in the world, had to officially recognize a disease. Since that time, of course, more and more physicians are aware of the fact that this is an illness which they should take care of.

Now, this is not unanimous by any means; there are still many physicians who are prejudiced, just as there are many laymen who are prejudiced. They still look at alcoholism as a behavior problem—something that will power can cure. But I think that we will learn as we go along. And I'm sure that more and more physicians will recognize al-

(Continued on page 15)

Tuberculous-Alcoholic

Would you please put me on your mailing list? This is the Franklin County Ohio Tuberculosis Sanitarium and we feel *Inventory* would be helpful to us in our department working with the alcoholic-tuberculous patient. Thank you.

Coreda B. Ward
Director, Social Service
Columbus, Ohio

School Libraries

Please send *Inventory* to the libraries of the following schools in our unit: Creswell Elementary School, Creswell, N. C.; Fourth Street School, Plymouth, N. C.; and Roper Elementary School, Roper, N. C.

Mrs. Gale W. Lucas
Supervisor
Washington County Schools

Al-Anon Family Group

I have just returned from the World Service Conference of the Al-Anon Family Group in New York. They would be happy to receive copies of *Inventory*. Would you please mail them to Al-Anon Family Group Headquarters, Box 182, Madison Square Station, New York, N. Y.?

Anonymous
Sanford, N. C.

In Doctor's Office

I saw a copy of *Inventory* in Dr. Farmer's office in Grensboro today and was very much impressed. Would you place me on the mailing list?

Anonymous
Albemarle, N. C.

Materials for Mental Health Clinic

Please furnish our clinic with current copies of the *Directory of Facilities for Alcoholics and Their Families in North Carolina* and *North Carolina Directory, Sources of Help for the Alcoholic and His Family.*

Mrs. Joyce Pickrel
Psychiatric Social Worker
Robeson Co. Mental Health Clinic
Lumberton, N. C.

Former North Carolinian

I am now in the process of setting up a local alcoholism program and would like very much to be placed on your mailing list. Being a former North Carolinian, I have read *Inventory* on many occasions.

Raymond E. Washington
Coordinator
Alcoholism Information Center
of Kanawha County
Charleston, West Va.

Expresses Gratitude

I wish to express my gratitude for the magazine, *Inventory.*

Alcoholism has been continuously brought to my attention in the past ten years as I repeatedly failed to properly educate my dearest friend to the perils of alcoholism.

Now with the aid of *Inventory* and A.A. this friend has seen the light.

My dearest friend, you see, is my wife. Please keep my name on your mailing list.

Anonymous
Physician & Surgeon
Out-of-State

VOL. 15, NO. 1 INVENTORY MAY-JUNE, 1965

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

A medical practitioner asks, "How can we ask the public at large to change its attitude and to consider alcoholics as sick persons when the great majority of doctors do not consider them as such?"

ALCOHOLISM REVISED

'Who Says Alcoholism Is a Hopeless Problem"

BY MICHAEL SHENKMAN, M.D.

THE status of chronic alcoholism in our country is deadlocked. The fate of over 5 million people, victims of this dreadful disease is in a stalemate, stagnant, without a hopeful outlook for a cure or improvement.

Mark Twain's dictum about the weather, namely, that everybody is talking about it but not doing anything to improve it, can easily but partially be applied to chronic alcoholism. A great deal of effort is displayed across the land in the realm of treatment and education on the problem of alcoholism. Year after year, scores of articles, papers, statistical data, studies, and endless discussions are scattered in our scientific and medical journals, but their effect upon the overall betterment of the problem is insignificant; their voices sound like a dim echo in a vast desert.

As reported in "Medical Tribune" (August 22, 1964) by Dr. William H. Steward, chief of a new ad hoc committee on alcoholism formed by the Department of Health, Education and Welfare, about 200,000 new alcoholic cases are reported annually.

On the other hand, one established fact is particularly stressed and repeated over and over again, namely, that alcoholism is the fourth ranking disease which is crippling the health of our nation, taking its place after heart disease, cancer, and mental illness.

The Secretary of Health, Education and Welfare, Anthony J. Celebrezze, admits that: "The problem of chronic alcoholism is old, persistent, difficult, and that solutions to date are nearly nonexistent." Why? Why this pessimistic minds-and-hearts-down-approach to a vital problem which endangers the health of our nation? On this matter, may we strongly disagree with the Honorable Secretary

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of HEW.

It is the purpose of this paper to take a frank and blunt look at chronic alcoholism, as a man engaged in the practice of medicine sees it, and to come up with some down-to-earth practical suggestions and ideas, which will permit one to have a "firm grip on the bull's horns," the only and sure way to do something tangible about it.

Since 1956, the American Medical Association recognized chronic alcoholism as a disease entity. The American Hospital Association, medical schools across the nation, state agencies, health departments in many states, have all endorsed the disease concept and work persistently and constantly through different programs to improve and help all those of our population affected of this dreadful disease. The results as of today, however, are discouraging (See New York City Report on Alcoholism published 1963).

Regrettable Fact

Why? Why is this so?

The only answer, as we can see it, can be found in the regrettable fact that the great majority of American doctors dissociate themselves from chronic alcoholism, avoid treating alcoholics, are not prepared to treat them, or send them off haphazardly to the Alcoholics Anonymous, as if this recommendable fellowship of men would represent the greatest panacea against suffering which humanity has ever created.

A great majority of professional men are victimized with stereotyped cliche-like conceptions about chronic alcoholism which are diametrically opposed to the views that the American Medical Association has on this subject. Such a discrepancy of views, such a paradoxical approach to a "fourth ranking disease which is crippling our nation," is not only inconceivable, but jeopardizes common sense and utmost responsibility towards the welfare of our people.

If alcoholism is a disease, as the American Medical Association duly recognizes it to be, then it is high time that a synchronized effort be made by the AMA to break through, to dissipate, to disperse the screen of obsolete misconceptions, old wives tales, and false beliefs about alcoholism which are so deeply rooted in the minds and hearts of our people at large and among our own professional groups as well. Let the AMA use its editorial pages to call upon all medical societies across our land to face chronic alcoholism objectively and courageously, and accept it as a disease. Time has come when the alcoholic, the living human individual, has to be rid of all stigmata, from all prejudicial looks and condemnation, from being cast out and degraded. Let our doctors be convinced that the alcoholic is a sick person, as sick as one can be from a psychoneurosis, peptic ulcer, or ulcerative colitis. Alcoholism should no longer be considered an underdog problem just because scores of other problems are directly entangled and interwoven with the central part of it, its intrinsic pathological component.

I have no intention to repeat the pros and cons of the disease concept of alcoholism. They are all common knowledge. I would like only to cite Jellinek's own words in regards to the alcoholic's "benders": "The onset of prolonged intoxications, this drinking behavior involves a great social risk. Only an originally psychopathic personality or a person who has later in life undergone a psychological process would expose himself to such a risk."

Amplifying this statement, we can

certainly say that a father of small children, a holder of a responsible job, a man of recognized reputation in his community who intermittently affirms that he adores his wife, loves his offspring, and who at the same time destroys his health, undermines his reputation and his happiness, neglects his family, all this through consumption of alcohol, is gravely ill. This man is terribly sick and in need of urgent treatment. The name of this pathological entity is none other than chronic alcoholism. Whatever the present status of the causative factors of this disease may be, the Res Ipsa Loquitur approach to the overall problem of alcoholism is undeniable and self-evident. To stress and to emphasize again and over again that the recovery of the alcoholic depends essentially and only on his desire to get well, on his willpower to stay sober, is inconsistent, evasive, and unjust unless we, the doctors, will come out with planning, suggestions and ideas as we usually do in attacking any other disease of epidemiological character. In other words:

A. Anyone affected by and suffering from alcoholism has to be considered as a patient.

B. And as a patient, he automatically belongs to a doctor's office, to a hospital, or an instiution or agency under the direct leadership, supervision and responsibility of the medical profession.

Let us repeat clearly and loudly: Where sickness is concerned, there is only one voice to be heard . . . the doctor's.

Of course, this does not mean that the doctor alone can and will solve the problem of alcoholism. Such a viewpoint cannot be farther from the truth. A coordinated team approach to the problem is mandatory, for alcoholism is of multidisciplinary concern. Its implications are widespread and deeply rooted. The cooperation of spiritual leaders, psychologists, trained counselors, nurses, social workers, and lawyers are of paramount importance. Inasmuch as the heart of the problem is a disease problem, organized medicine has to be found in the first line of attack. Without the doctor, any program of rehabilitation for the alcoholics is doomed to failure.

We can wholeheartedly agree with Dr. Ebbe C. Hoff when he says: "The team approach to the therapy of these patients (alcoholics) and their families, is based upon the concept of a multiple constellation of etiological factors."

Combination of Causes

It seems very likely that there is no single causative factor but that the illness of these patients is due to a combination of causes: metabolic, psychologic, social, and cultural. Moreover, the alcoholic is usually not ill in only one system but is, so to speak, "ill all over." This down-to-earth statement emphasizes so clearly the point of view we are trying to bring out, namely, that exactly because the alcoholic patient is ill all over, the responsibility of the overall outlay of team work has to fall upon the general physician. Without diminishing or underestimating the high quality work displayed by others, it must be emphasized that it is not even the psychiatrist or the psychologist, the dedicated clergyman or the highly trained social worker, the educator or the sociologist, who can envision and encompass the whole pathological picture of the alcoholic. As of today, for one reason or another, the physician is not exercising this challenging responsibility. That is why we are failing in our attempt to accomplish something substantial

in the treatment and prevention of alcoholism.

Dr. Hoff made another important statement I would like to quote: "A most urgent requirement in enhancing the success rate in the treatment of alcoholics is a more accepting public attitude towards alcoholics as sick persons." It is certainly proper to ask Dr. Hoff how, in heaven, can we ask the public at large to change its attitude and to consider alcoholics as sick persons, when the great majority of doctors do not consider them as such.

So it becomes clear that the doctors themselves would have to change their own attitudes towards the alcoholic, to come out clearly and loudly making it known to their own communities. Only then can we legitimately expect that the community's attitude will also change.

How can this be accomplished?

1. The National Committee on Alcoholism, sponsored by the American Medical Association, has to take the initiative for the organization of a symposium dedicated to alcoholism. The participants of this symposium have to be representatives of our medical schools, hospitals across the land, and experts in the field of alcoholism.

2. The recognition of alcoholism as a disease should be reaffirmed and released to the press.

3. A scientific armistice would thereby be declared: to stop the endless discussions over alcoholism—the symptom, alcoholism—a behavioral phenomenon, alcoholism—a moral issue. Instead, alcoholism—the disease would have to be fully discussed and the ways and means to combat and prevent it would have to be formulated. It should be mentioned that we are not considering here social drinking in general. Up to eighty percent of our adult population may drink alcoholic beverages. We are concerned with the ten percent drinkers who really do not drink, but consume their alcohol and therefore are sick.

4. Time has come when the subject of alcoholism should be taught in medical schools. A tentative curriculum on this subject was prepared and made available to all medical schools by the national committee on alcoholism.

5. The knowledge accumulated in the field of alcoholism is so great and diversified that at each medical school, at each hospital, an ad hoc department, a department of alcoholism would have to be formed. Furthermore, these departments should be encouraged and provided with the proper means to engage in active research dedicated to aspects of the alcoholism problem.

6. It is time for the medical profession to stop repeating the same concepts and views which the people at large hold about alcoholism and alcoholics. "Yes, he is an alcoholic, she is an alcoholic, they are drunkards," and the like. It would be a great step forward towards the rehabilitation of the alcoholic if the words alcoholism and alcoholic would be cut, forgotten and buried forever. It was an unfortunate day when the concept of the Problem Drinker was invented, and given to the people and to the doctors. What we have accomplished with it is the watering-out of the disease component in it, and so we helped the medical profession to stay away from the field of alcoholism and from its victims. A drinking problem does not imply a disease problem and when illness is not implied, it is easy for the doctor to evade the issue completely.

7. E. M. Jellinek is called by all right the Dean of Research on alcohol and alcoholism. It was he who came out with the classification of the alcoholisms, declaring that the so-called Gamma type of alcoholism, the dominant type of alcoholism in the United States, has the intrinsic elements to be classified as a disease per se. It was he who outlined the phaseology of alcoholism.

E. M. Jellinek died the twenty-second of October, 1963.

I think that there could not be a better way to perpetuate the memory of this internationally known man than by replacing *Alcoholism* with the name, *Jellinek's Disease*. By doing so, not only justice would be done in honoring a great scientist, but also the cause itself for which he dedicated his life would be enhanced and dignified. Let the people speak about alcoholism; let the medical profession begin to use the term Jellinek's disease. People will listen to it and will gradually accept it, and so Cain's brand will gradually fade away from all those affected of Jellinek's disease.

8. *Alcoholism and the admission policies in our hospitals.* It is well known that for the victims of chronic alcoholism the doors of the great majority of our hospitals are closed. This is another inconsistent pattern of reaction to a sector of sick people afflicted with the "fourth ranking disease which cripples the health of our nation." This discrepancy of hospital management towards the alcoholics becomes distressingly obvious, especially, if we acknowledge the American Hospital Association's recognition of alcoholism as a disease and its recommendation to the hospitals to have their doors open for the alcoholics.

This situation can easily be corrected if accreditation privileges for the hospitals could be placed in jeopardy in case alcoholics are not admitted.

Although the fellowship of Alcoholics Anonymous is commendable for the genuine effort of its members to help themselves and to attain total abstinence, it is regrettable that the people at large and especially the medical profession overestimate the potential of this group in the overall program of the rehabilitation of alcoholics.

Alcoholics Anonymous became a common denominator for almost everybody including a great majority of physicians who immediately think of A.A. when they face alcoholics in their office.

It is unfair and unjust to refer an alcoholic to a nonmedical unit as his only place for rehabilitation without evaluating him "alcoholically" so to speak, without obtaining a systematized history which reflects the dynamics and evolution of his sickness.

Let us say clearly:

The A.A.'s help themselves and try to help other alcoholics. However, only by the trained doctor or qualified trained nonmedical men and women, under the supervision and responsibility of the doctor can the alcoholic be treated.

I know of alcoholics who are attending A.A. meetings for years without having consulted a physician in connection with their Jellinek's disease. In order to study the relationship between the A.A.'s and the physician, I have prepared a "no signature required" questionnaire for the A.A.'s to fill out. (The results of this

study are awaiting publication).

One of the outlined questions is: Have you consulted a physician in relation to your alcoholic problem?

Of 119 collected answers I have so far, 39 have answered no (32.8%). Of those 39 NO answers:

15 attended A.A. meetings between 1 to 12 months
8 attended A.A. meetings between 13 to 24 months
5 attended A.A. meetings between 25 to 36 months
3 attended A.A. meetings between 37 to 48 months
3 attended A.A. meetings between 49 to 60 months (5 years)
3 attended A.A. meetings 6 years
1 attended A.A. meetings 9 years
1 attended A.A. meetings 16 years

I wonder how many of these A.A.'s are in need of medical evaluation and treatment for the sickness they try to get rid of through A.A. only?

Summary

The deadlock in the rehabilitation of the chronic alcoholic is due to the fact that organized medicine is not exercising its active creative leadership and does not participate directly in the rehabilitation programs. The scope of alcoholism and its impact on the health of our people calls for an all-out mobilization of medical resources—the only vital factor which will stimulate the community to participate as well.

Practical suggestions and ideas are outlined for their immediate adoption by an ad hoc organized symposium under the sponsorship of the National Committee on Alcoholism and the American Medical Association.

The introduction of alcoholism in the realm of medicine and the recognition by the doctors across the country of alcoholism as a disease is a sin qua non, a must, a very first step in the right direction.

A PHYSICIAN'S PHILOSOPHY

CONTINUED FROM PAGE 3

not only the treatment of the alcoholic but also the treatment of the other people in his world. I feel I can rarely help the seriously ill alcoholic without including his wife (or her husband), his mother or father and often his friendship group or his work group, if he is very close to these groups.

The physician must help the family and friends to realize that the problems the alcoholic faces are often due to the same pressure that all are under.

The physician is not a god. We must recognize our limitations and not let the patient use and abuse our services to the point of just prolonging his illness. This is always a difficult decision to make but these lines must often be drawn and pointed out. Otherwise the physician is just as guilty as the husband or wife who helps hide the alcoholic's illness.

It is said that the alcoholic needs unconditional, forgiving love. Many people interpret this as being an experience with God—a *reconciliation* or *restored relationship* — with the Higher Power. Dr. Edward Bauman writes in his recent book, *Beyond Belief,* that through *reconciliation* there comes to any man a new appreciation for his own potential selfhood, and he begins to relate to the world of material things and to other persons in new and creative ways. His life is so rich and new that he looks back and hardly recognizes the person he was before. This is the recovered alcoholic.

The physician should strive to lead the alcoholic toward this reconciliation with God. This way the alcoholic literally becomes a new being through the power of God's healing grace at the center of his existence.

CONTINUED FROM PAGE 7

coholism as a disease.

Q Even if they recognize it as a disease, do they have any good new ways of treating alcoholism?

A Oh, there are many. For instance, you take the drug, alcohol, that people use for the purposes that we described before—for tranquilization, for instance, to reduce their tensions, to allay their fears and their anxieties. Well, we now have other drugs, particularly some of the tranquilizers, which will help do this, and we can substitute those for the alcohol until the patient gets enough psychotherapy to learn how to live without alcohol.

Q Do drugs that make people ill if they drink do any good?

A They are a tremendous help in our therapy. There are two: One is disulfuram—Antabuse. There's another one—citrated calcium carbimide—called Temposil. These are wonderful adjuncts to the treatment, but they're not the answer to the problem. They are just one way of helping the alcoholic addict to abstain from alcohol.

Q How do they work?

A To make it very simple, one could say they turn the alcohol into a poison, so that the individual becomes terribly, terribly sick.

Q What good does that do?

A There are many alcoholics who are so addicted that they feel that they can't go for a full day without drinking—they couldn't stand it. So that these drugs are a great help. If the alcoholic takes the drug, he doesn't have to argue with himself, whether he should or shouldn't drink. The answer is there: He can't drink, and so he abstains. And when he goes for 24 hours without a drink and finds that nothing terrible has happened to him, this is a great source of encouragement to go on.

Q Suppose the individual does not want treatment?

A We have found through experience that even under duress, treatment is effective. A tremendous percentage of these people will respond to treatment even if it's done under force.

Q Who has tried that?

A This is particularly true in industry. We find where a man has the motivation of his job and is forced to undergo treatment in order to keep his job, he will respond very well in a great percentage of cases.

I think this can also be true when the treatment is given under duress by State or local law.

Q What laws are needed to help deal with alcoholism?

A I think that the law could do a great deal toward reducing the incidence of alcoholism if people who are adjudged alcoholic were given a certain amount of care and attention.

I also feel that the liquor laws should be enforced.

I feel that the advertising of liquor should be changed so as to take away the glamour, so that young people won't feel that there is something in alcohol, which it doesn't have. The idea that it gives one "distinction," or that there is such a thing as one beverage being safer than another, is erroneous.

"MILLIONS HAVE RECOVERED"—

Q Just how much hope is there for an alcoholic, even with present drugs, clinics, Alcoholics Anonymous, and all the rest?

A Millions of people have recovered. If there are 5 million alcoholics in the United States at this date, I would say that at least that many more have recovered over the years.

Q Doctor, do you see a time when alcoholism will no longer be a problem in the U.S.?

A I don't think I would go that far, because there are few diseases that have ever been completely eradicated. But I think that the reduction of the percentage of alcoholism in this country and the number of alcoholics can be considerable.

I think that a great deal of progress can be made. With proper research and treatment facilities, I think that we can help most of the alcoholics.

There is no such thing as a hopeless alcoholic. They can all be helped, if we want to invest the time and the effort to do it. **(THE END)**

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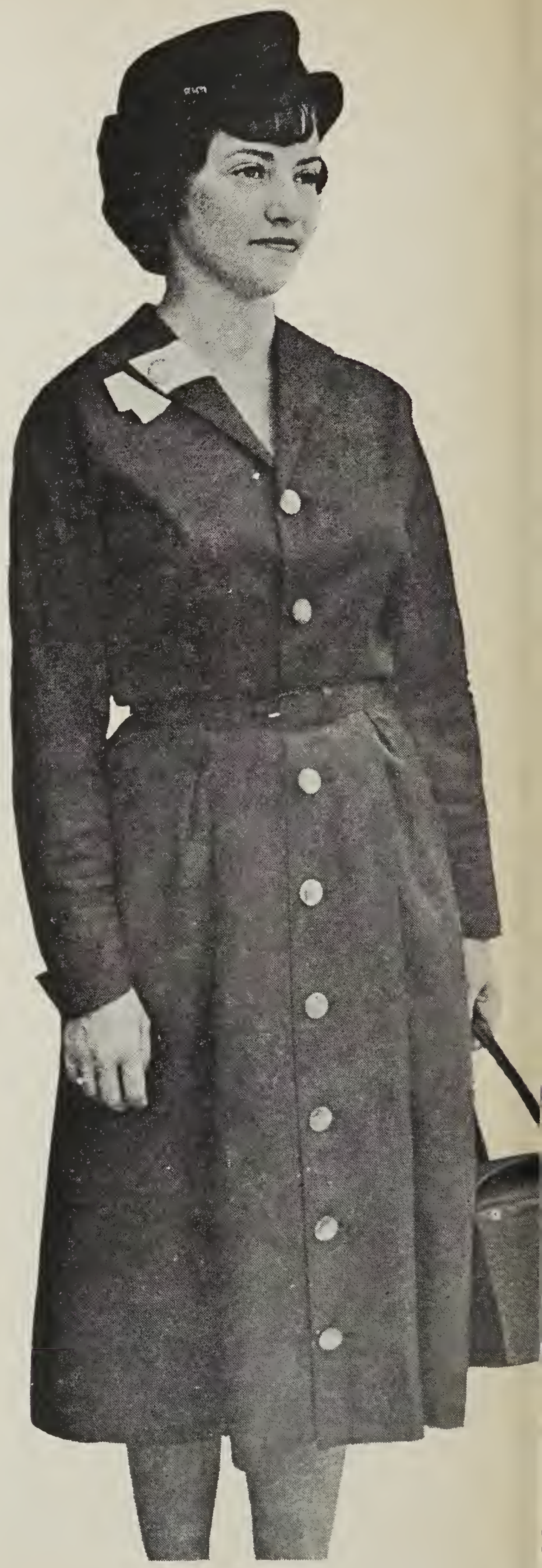
BY HOWARD T. BLANE AND MARJORIE J. HILL



WHETHER alcoholism is regarded as a specific disorder or as the symptom of a number of underlying emotional problems, it is distinguished from many other psychiatric conditions by its widespread impact on the family and community, as well as on the individual. Traditionally, however, the problem has been treated as though it were a problem of the patient alone. The doctor in a private office and the staffs of clinics and hospital psychiatric wards see the alcoholic patient apart from the environmental conditions which contribute to, and are in part caused by, his problem drinking. Of all the caretaking professions, public health nursing provides perhaps the greatest opportunity to observe the patient in his natural setting at home and with his family.

The public health nurse's professional orientation is toward preventive medicine, and the "public health approach" involves the principles of primary, secondary, and tertiary prevention. The application of these concepts to alcoholism has been described as follows:

Primary prevention is the use of social, chemical, or biological procedures to prevent the onset of alcoholism. Secondary prevention consists of early intervention in excessive,

Of all caretaking professions, public health nursing probably provides the greatest opportunity to observe the patient in his natural setting.

PUBLIC HEALTH NURSES SPEAK UP ABOUT ALCOHOLISM

pathological drinking by medical and/or social means to prevent the major consequences of alcoholism. Tertiary prevention involves rehabilitative efforts for the chronic alcoholic in order to avoid further complications of his illness and prevent the spread of its influence to others in the alcoholic's environment.

In any of these phases of treatment, it would seem, the public health nurse is in a unique position to identify the problems involved, provide information and assistance to the patient and his family, and thus to serve as a valuable adjunct to treatment resources.

As part of the research program of the alcoholic clinic of the Massachusetts General Hospital, we undertook to interview a number of public health nurses in the Boston area in an attempt to determine the extent of their awareness of alcohol-related problems in the community, their attitudes toward the patient and toward treatment, and their role in identifying and referring alcoholics.

The city of Boston has features which make it especially interesting for the study of alcohol-related problems. It has a large Irish-American population, traditionally a group which contributes heavily to problem drinking, as well as concentrated Italian and Jewish populations, also known to have culturally influenced drinking patterns. The problems of Boston's extensive skid-row area are currently being complicated by a large scale urban renewal program.

The nurses in our sample were drawn from the Visiting Nurse Association (VNA) of Boston, which has a central office, eight district offices, and a professional staff of 75. The VNA provides nursing care and physical therapy to acutely and chronically ill patients in their homes; instruction in maternal and infant care; family guidance in child development, nutrition, prevention of illness, and advancement of mental and physical health. Although nursing care is provided under doctors' orders, the nurses of the VNA through their program of health guidance, serve as teachers in physical and mental health, and in this way reach members of the family other than the immediate patient.

One nurse described this program as "a public health nurse's way of adding patients to her caseload. It's a nurse's way of teaching the community without having doctor's orders . . . it can be in any field." Another said, "We can sit down and tell them what conditions need medical attention and where to get help." As the nurses describe the program, it involves instruction in nutrition, in

maternal and child care, and in care of the sick at home.

Our study sample included the supervisors of the eight district offices and either one or two staff nurses (depending on the size of the office) who were randomly selected within each district. A total of 20 nurses were interviewed during a period of one month in the summer of 1962, and interviews were tape recorded except in cases of mechanical difficulties or refusal, when shorthand notes were taken.

The nurses ranged in age from twenty-four through sixty-seven, and in length of service with the VNA from six months to 34 years. Median age of the supervisors was forty-six, and of the staff nurses, thirty-one. One of the problems of an urban agency of this type is that of rapid turnover of the staff, which means that many nurses do not have the opportunity to acquaint themselves thoroughly with problem areas and the available resources, thus increasing the responsibility of the supervisors. In our sample, we found that, while median length of service of the supervisors was 14 years, 67 percent of the staff nurses had been with the agency for three years or less, with a median service of two years.

Eighteen of the 20 nurses indicated that they drink socially, most very rarely; six reported that their families had been strongly against liquor during their childhood. Only three nurses indicated that they had never known a problem drinker or an alcoholic personally, and six reported problem drinking among their relatives.

It is interesting to note that in a city which ranks fourth in the nation in rate of alcoholism, most of the staff nurses reported that they rarely encounter cases of alcoholism. The supervisors, however, who direct

Opportunities in prevention an

from four to nine nurses and the areas they cover, generally saw alcohol addiction as a serious problem. The interview material points to several possible reasons for this discrepancy. One of these was the limited nature of our sample, and specific features of the areas covered by the nurses we interviewed. One nurse, for example, reported that 99 percent of her patients are Jewish and drink very little; another, who works in a district consisting almost entirely of Italian families told us that she sees much drinking, but no alcoholism. The two nurses who work in Boston's skid-row area said that they see very little drinking in the homes they visit, although they realize that it is a serious problem in that neighborhood.

A more cogent explanation is that the supervisors, most of whom have been with the VNA much longer than the staff nurses, are better able to recognize the problem. As one of them put it, "It takes a while to sort out the problem areas, and by the time they [the staff nurses] know what the problems are, they are likely to leave the agency. So they don't have time to learn to be attuned to alcoholism in the home; being attuned is something one learns. The nurses who stay develop a sensitivity."

The nurses' comments suggest that a lack of sensitivity may result from their tendency to regard drinking behavior as a problem only when it has become extreme. Several reported that their only contact with alcoholics occurred while they were working in hospitals, and this may have led them to identify an alcoholic as one who "can't function," blinding them to symptoms of potential

arly casefinding are lost if "extreme alcoholism" is the focus.

drinking problems. Most of the nurses distinguished between heavy drinkers and alcoholics; for example, "a heavy drinker would drink quite a bit, get drunk, but still be able to hold on to a job and carry out the basic responsibilities of his family life . . . whereas the alcoholic would cease functioning, just drink." Another felt that heavy drinkers become alcoholic "when they lose their responsibility toward their family or their breadwinning . . . or can't control themselves in the community . . . when the community begins speaking of these as always drunk."

When asked for their definitions, some of the nurses again tended to be extreme. "Somebody who doesn't eat, and drinks . . . who disregards nutrition altogether, and will spend his last penny for a bottle of alcohol rather than have something to eat." "Somebody who needs alcohol in order to survive . . . or to carry out, or cope with, day to day existence." "They can't stop drinking. They drink from morning till night. They will use up all their financial resources to buy liquor."

The use of extreme definitions is in large part a reflection of the first concern of the nurses—to care for the physically ill member of the family who has been referred to them by the doctor. Where drinking complicates the medical problem, for example in diabetes, they are quick to recognize it. A supervisor said, "In defense of the nurse, there are so many other things! She's often meeting the needs of the moment, rather than getting involved in a long-term process." The patient, then, tends to be the nurse's first concern, even though she may recognize that other family members have problems which should receive attention. Partly because of the extent of her caseload, she often focuses only on alcoholism in its advanced stages, missing opportunities for preventive teaching and early casefinding.

When we speak of early casefinding, or primary and secondary prevention, we are concerned with what may be called "alcohol-related problems," rather than with extreme alcoholism. These problems are frequently encountered and described by the nurses who find that once a good relationship has been established with one member of a family, this person often regards the nurse as a confidante who will listen sympathetically to family problems, give advice, and whose professional status makes her a safe person in whom to confide. Many of these problems concern drinking by other family members.

The types of alcohol-related problems which the nurses encounter may be divided into several categories. First is the type of patient whose medical condition, for which he is being treated, is either caused or complicated by excessive consumption of alcohol, as for example, the patient suffering from malnutrition, or one with both arthritis and psoriasis.

In a second type of situation, the patient, usually the housewife, complains to the nurse about the drinking problems of another family member, usually her husband. Although the nurse may never meet the problem drinker, she often gives advice regarding treatment. One supervisor reported, "This woman who is so sick with cancer asked the nurse what could be done about her husband.

(Continued on page 26)

Should We Jail Alcoholics?

How an Archaic, Brutal Practice Wastes the Lives of Millions of Men and Women

BY SID ROSS

THE 10 men below represent the biggest single law-enforcement problem in the U. S. Among them, they have served more than 30 years behind bars, have been arrested a total of 1,023 times and have cost the taxpayer $300,000.

You might think that these men had committed some truly nefarious crime or that they are hardened, professional criminals. But the fact is that their offense is only a slight one —though they have committed it again and again. These 10 men are alcoholics—skid-row types who are not able to handle liquor and whose devotion to the bottle is complete. And modern America, for all its insights into alcoholism, its worship of psychiatry and its sympathy for the under-privileged, can think of no solution other than to put them in jail.

In all parts of the U. S., in cities large and small, unfortunates like these are handled in the same fruitless, callous way. Through indifference and ignorance they are treated as criminals rather than as the help-

Reprinted, with permission, from the February 14, 1965 issue of *Parade*.

"Life sentences on the installment plan": group portrait shows 10 Monroe County, N. Y., men who have served total of 90 years for drunkenness charges. Senior man has been behind bars a total of 14 years in short stays.

less and inadequate individuals they are. On any given night, they account for one-half to two-thirds of U. S. jail inmates—by one estimate, 1 million a year!

They clutter up the courts, monopolize policemen's time and cost the taxpayers millions. And worst of all, they get little treatment or care, so that many come back again the very next night.

"It's a revolving door that never stops whirling," Donald H. Goff, general secretary of the Correctional Association of New York, told a state legislative committee investigating the problem recently. "These men are serving life sentences on the installment plan." Moreover, the situation seems to be getting worse. From 75 to 80 per cent of those arrested are "repeaters," many with 250 or more arrests for drunkenness in a lifetime. In Monroe County, N. Y., where the men at left were photographed, drunks make up 77 per cent of all arrests.

But at least Monroe County is trying to do something about the problem. A concerted effort by public agencies, private industry and civic groups will soon result in an excellent program focused around a new rehabilitation center. But the real tragedy is that far too few municipalities are following Monroe County's lead. For, knowing what we do about alcoholism, psychology and rehabilitation, the U. S. could alleviate the alcoholics-in-jail problem—if not eliminate it.

Instead, PARADE found, drunks are being subjected to brutal, inhuman—and futile—treatment. Rockford, Ill., locks them in a gloomy basement called "The Pit"; nearby Joliet puts them in a ghastly "drunk tank"; Chicago keeps them in 11-by-12 cells whose odor is intolerable. In San Francisco, police conduct regular tours to "sweep the streets." In St. Louis, on the other hand, they ignore all but "lying-down" drunks. "We're humane," says one police official. "We don't bother a guy if he can stand or stagger." But at least St. Louis takes all arrested drunks to a hospital for examination before jailing them.

Even more appalling is the waste

In court, San Francisco women hear sentences meted out by magistrate. About 1 in 10 skid-rowers is a woman.

One man's record—six feet of single-spaced typed arrests—is displayed by policeman at St. Petersburg, Fla.

of human life which these cases represent. Most people think of skid-row drunks as worthless bums, yet many are men—and some are women—of skill and high intelligence. However, PARADE found most cities offering little more than the vestiges of treatment, help or rehabilitation. Consequently some drunks spend almost their entire lives behind bars. Among the examples:

In San Francisco, where 24,000 persons were arrested on drunk charges in 1963, PARADE talked to a 43-year-old man who had spent 285 days behind bars that year. He had been arrested 148 times since 1957.

In Nashville, Tenn., police told the story of Wilma and Theodore Cooper, who had been married for 30 years, been arrested 450 times, and had spent a grand total of 25 years of their married life in jail.

In several places, PARADE found that drunks, knowing their own inability to change and accepting the futility of the system, used the local jail as their home address and even received mail and pension checks there. In the Washington, D. C., workhouse, several regular customers even left their false teeth in the warden's custody, knowing they would be back and would need them to eat with.

In most cities, the system of handling drunks is a legalistic farce. Often they are held only overnight and then released the next day on "probation," "suspended sentence" or their "own recognizance." Sometimes they are assessed a token fine—$5 or $10. Hypocritically, those who can afford it are allowed to post bond (usually $10) when arrested—and then forfeit it. And some of the drunks are sentenced to short terms—30, 60 or 90 days—or fined, and if unable to pay—as is customarily the case—they are allowed to work off their sentence at so much per day.

Of course, it would be exceedingly difficult to map and make effective any rehabilitation for these persons. Alcoholism is a baffling problem in any person, and the bafflement is compounded in skid-row types. "These people's inadequacies," Judge William H. Burnett of Denver wrote recently, "would at most be only partially solved by sobriety." A study of police court alcoholics in Monroe County a few years ago found their major failure was one of interpersonal relations—an inability to cope with people.

But whatever the nature of the alcoholic's problem, authorities — including sheriffs' and jailers' organizations—agree that treatment, not

Sleeping it off, drunks sit and slump on floor of Miami jail "drunk tank." Furnitureless tank, 1 of 4, has capacity of 25 prisoners. Prisoners usually spend four hours in tank, are subsequently transferred to cells.

jail, is the solution.

PARADE spent a night in the jail in Providence, R. I. which in handling drunks is no better and no worse than most major cities — watching this exercise in futility play itself out. (Providence in 1963 chalked up 7,415 nontraffic arrests, of which nearly 3,000 were for drunkenness. On an average night more than 20 persons are picked up on drunk charges.)

On the night of PARADE's visit, the drunks began arriving early. The first was a 47-year-old who had celebrated too much. This was only his second arrest for drunkenness. He was clapped into a bare-floored "drunk tank" cell to sleep it off on an iron bench.

Moments later, the regulars began to arrive. A young bricklayer, in his 20's, was first. "He's on his way already," a jailer said. He was followed by an old regular, a violent, abusive type who immediately began to argue with the younger man. Next came a laborer police had arrested several times before. They had to twist his arms and sit on him before they were able to get him into a cell. The next group, old hands, were benign and gentle. They went meekly into their cells and lay down. Meanwhile, in another wing, police jailed two women. Finally, at 4 a.m., the flow stopped.

In all that time, however, the prisioners received only meager custodial care. Nor did they get any treatment after hearings the next morning. An Alcoholics Anonymous representative was on hand to aid those who asked for help, but there was no doctor, psychiatrist or welfare worker. "The City of Providence," one jailer said, "wouldn't spent a damn nickel on these people."

Providence is not alone in this respect. To taste the full flavor of futility as dispensed to drunks, one needs to spend a morning in a magistrate's court. In San Francisco's "Drunk Court," PARADE watched Judge Bernard Glickfeld mete out justice to 60 male drunks and 6 women in 45 minutes flat. After an attendant had sprayed the courtroom with insecticide, the judge called the women prisoners, questioned each briefly, delivered a few homilies and then put them all on probation. Then he called the men 25 at a time. Each humbly pleaded guilty, some with merely a nod. The judge tried to deal with each individually. "You were here yesterday," he told one seedy derelect. To another he said, "We'll

try to get you medical attention," To a third, "You need help. Ten days in jail will fix you up." While the attendant sprayed again, the judge gave some 30 to 60 days and urged them to straighten up. Many received suspended sentences, which put them right back on skid row again.

Ironically, some experts say, this kind of humane treatment is part of the problem. Short stays in jail do no good and may do harm. "How can you hope to accomplish anything in 5, 10 or 30 days?" asks Donald Goff of the Correctional Association.

Why are drunks sentenced to this perennial merry-go-round? Some officials say their hands are tied—"All I can do is what the law says," one contends. Others rationalize that drunks must be arrested for their own protection and that of society—or argue that the men want to be picked up. "To many of them, this is the only home they know," said a jailer in Florida.

Yet the real reasons for jailing are less benevolent. Basically, they boil down to these:

1) The punishment theory. In the past, Americans considered — and many still consider—drinking a sin. Given a jail term, it was reasoned, the sinner would repent and reform. Now science considers alcoholism an illness. But the old notion of punishing the sinner remains locked in law and practice.

2) Indifference. Mental patients have families; even criminals generally have wives and children. Police court drunks usually have no one. "These men have been repudiated by everyone—even themselves," says Warden Thomas Riley of the Monroe County Penitentiary.

3) False economy. Rehabilitative treatment costs money, and taxpayers balk at setting up such programs. Yet one drunk, in a lifetime of drinking, may cost society $50,000 to $100,000. He might possibly be rehabilitated for a fraction of that.

4) Lack of facilities. Psychiatric hospitals have no room; medical hospitals have no facilities; social agencies avoid drunks; penitentiaries are for major offenders; private sanitariums cost too much. The few pioneering long-term treatment centers can accommodate only a handful. By elimination, that leaves jail.

5) The feeling of hopelessness. Even sympathetic observers agree that hard-core alcoholics resist reform. Many go further and say they are hopeless. After years of slavish drinking, it is unlikely that skid-rowers will turn their backs on the bottle and start a new life. So why not write them off, give them the care they require to protect themselves and others and spend as little of society's money as possible on them?

Is the situation really that hopeless? Can nothing be done to salvage these lives, to remedy the procedure that brings these men back to jail again and again?

While no one has all the answers, the fact is that something can be—and is being—done in such cities as Fort Worth, Washington, Miami, Los Angeles and San Francisco.

Los Angeles, for example, boasts the much-admired Saugus Rehabilitation Center. It has excellent medical, psychological, psychiatric and sociological facilities, can handle 1,200 inmates. Officials admit, however, that Saugus lacks good follow-up.

San Francisco, too, has an enlightened program, which emphasizes, in equal measure, counseling, psychiatry, fresh air and hard work and is largely the work of Sheriff Matthew

Carberry.

Perhaps one of the most remarkable programs is that of the Chicago Alcoholic Treatment Center, a small 72-bed facility run by a dedicated staff as part of a municipal hospital. The center brings to bear on each case a team of physician, psychiatrist, sociologist, and it tailors treatment to the individual. Patients get lengthy counseling, group therapy, are allowed to govern their own affairs and are given plentiful vocational education, recreation and group sessions. One special feature is a weekly family meeting to help the patient's family (when he has one) understand his problem. The center also has a job placement program and good, if limited, follow up. Last year a study of 523 patients showed 514 "significantly improved." The center's drawback, however, is its limited space.

And some experts think that no institution, no matter how progressive, is the real answer. What is really needed, these men contend, is to take the problem out of the hands of law-enforcement agencies and turn it over to public health. An adequate program would place the emphasis on research—to find out what makes these men what they are—and establish a plan for rehabilitation, with particular stress on vocational training and follow-up. Finally, the program would call for new dormitory-type, nonjail facilities for those drinkers too far gone to be salvaged.

Although such a program would cost considerable money, experts think it would pay off in the end. In any case, they feel that some rehabilitation effort should be initiated. Merely to end the practice of jailing drunks would be a beginning.

The experts believe you and your friends should begin to investigate the matter in your own communities, talk it up at civic groups, bring pressure to bear on political leaders for more humane treatment of alcoholics, urge a complete and up-to-date program for rehabilitation.

"It is not merely enough to say, 'There but for the grace of God, go I,'" one official told PARADE. And San Francisco sheriff Matt Carberry adds: "I don't go along with the philosophy that nothing can be done for the chronic alcoholic. You just can't turn your back on human beings."

Hope for future is represented by farmlike Saugus Rehabilitation Center near Los Angeles. Experts say good institutions and programs help solve problem.

CONTINUED FROM PAGE 19

The nurse took the case on for health guidance, for help with alcoholism. We found out that he was a veteran, known to the Veterans clinic, and that htey were willing to help."

Least frequently reported by the nurses are patients who themselves ask for help specifically for their drinking problems. In describing such an incident, a nurse related: "Yesterday I had a telephone call from one of our former patients who is in a nursing home, very happy, and doing very well. She wanted to thank the nurse who worked with her and encouraged her to go to a home where she wouldn't have access to the quantities of wine she'd been drinking. The nurse had been seeing her for bouts of diarrhea, nausea, and vomiting."

There is also the case of a drinking problem so severe that it prevents the nurse from seeing the patient at all. Often he is so neglectful of the condition, for which visiting nurse service has been requested, that he fails to cooperate by staying home for the nurse's visits. Among such patients reported by the nurses was a man with an ulcer on his leg which required regular treatment, and a tuberculosis patient much in need of supervision.

In a fifth type of situation, the one which arises most frequently, the nurse is aware of a drinking problem, but is not asked for advice. Sometimes she feels free to initiate a discussion of the subject; in other cases she does not. One of our participants told the following story:

"I visited a young girl who has been drinking since she was an early teen-ager. She said she only went on weekend binges, but she stayed indoors with all the shades drawn, never went out. She was living with a man who was not the father of her baby; the pregnancy was the result of a weekend binge which she was later unable to remember. She didn't say she needed help, but I kept asking her. I brought it up in connection with her being unable to keep her baby; one of her neighbors had reported her, and she was threatened with the loss of her child. We referred her to a family service, but they wouldn't take her on. And so we decided to resume our visits, but were never able to get into the house again."

On the whole, the nurses expressed accepting attitudes toward alcoholics "when they are sober," describing them as people who are generally charming, polite, and likeable; ". . . these people I've met who drink too much, I find them friendly people, good hearted." Some nurses saw them as weak people, "little lost sheep," with a loss of self-control which one nurse described as "character degeneration;" others saw them as sick people in need of medical help, "the same way we would treat any other disease."

The drinking alcoholic, however, elicits a great deal of ambivalence, and some of the nurses were aware of this. One said, "It's easy to sit here and talk about alcoholics whom you see for an hour at a time, but that's entirely different from having to live with them; that would be terrible." A supervisor added, "Suppose that a nurse had, for example, an alcoholic uncle who had caused a great deal of strain, stress, and embarrassment to the family, and she went to take care of other alcoholics. I think it's a rare nurse who would deal with this objectively."

Some nurses recognized, and were frank in expressing, their own negative attitudes: "The alcoholic person

. . . becomes rather disgusting in a lot of ways." "I think it's very depressing, working with an alcoholic." Most, however, were more likely to ascribe unfavorable attitudes to other people, and to other nurses. If we assume that it is easier to express one's own feelings when generalizing about the attitudes of others, the ambivalence becomes clear. For example, throughout the interviews there was an undercurrent of fear of violence. Only one nurse expressed this directly, as part of her own experience. Several, however, ascribed fear to other nurses: "I think new nurses are sometimes afraid of them." "They're unpredictable in what they might do, so that we have to be cautious in dealing with them." None of the nurses had heard of an actual case of violence involving a nurse.

Three of the nurses indicated that their own attitudes have changed within recent years, largely as a result of reading and public education programs. One said, "I've changed my feelings about it as I've grown older, and since I've had more experience. I used to think . . . the people could help themselves. When I was younger I never considered it a disease, I just thought of it as an easy way out of things for some people."

Some of the nurses are aware that their attitudes toward the alcoholic may determine their effectiveness in helping him. "I have real feelings about alcoholics," said one. Another admitted: "I just could never, never work with them. I know it, and this may be a failing, but I would never have the patience to. It would not be fair to the patients to force myself to work with them." A third nurse: "In my opinion, it would take a certain kind of person to work with alcoholics, because you're going to have a large number of failures."

It is not surprising that the public health nurse, like most people in the medical professions, likes to see improvement in her patients, and to bring about observable changes. As a result, she may fail to find personal satisfaction in work with alcoholics. One of the nurses said: "I think a lot of us tend to feel it's somewhat unrewarding. Most nurses like to see something that really changes, or that works fast . . . but with alcoholics you don't get this."

Almost half of the nurses interviewed regard treatment of alcohol problems as discouraging and hopeless: "What can you do with people who don't want advice, or who won't help themselves?" One nurse asked another for advice, and was told, "We don't take care of a person like that, because you'd just get them all fixed up and think that you might be getting somewhere, and they'd go out and have another spree, and you have to start all over again." Again, "We have worked awfully hard with some families, and it just sort of went down the drain."

Other nurses find work with alcohol problems to be challenging, and the results of their efforts rewarding. Nine of those we interviewed expressed this viewpoint, saying, for example, "I find it a challenge to work with them, to try to discover what bothers them, and then see if something can be done." Nurses are aware of the impact that alcohol-related problems may have on the family, and the family is usually their first concern. One said: "Maybe the reason that I want to help is because I see what it's doing to the family, not just the patient . . . I'm not always sure we're thinking that the patient wouldn't have to suffer, but rather that the family would be better off if you helped him."

In reading the cases included in the

(Continued on page 30)

ZIP CODE NOTICE: In compliance with the ruling of the Post Office Department, the mailing address of each subscriber to INVENTORY within the United States must show the zip code number. Miss Eleanor Brooks, circulation manager, requests that subscribers send this information to her at their earliest convenience. A post card will suffice. There is time for a gradual changeover but, eventually, addresses without the zip code number will have to be deleted from the mailing list. Thanks for your cooperation. Address your post card to: INVENTORY, Box 9494, Raleigh, N. C. 27602.

POLICE TRAINING FILM: Two prints of a new educational film, "The Mask," have been placed in the Film Library, State Board of Health, and are available to interested persons, groups and organizations throughout the State. The police officer of today must be an individual who brings knowledge to the job—knowledge which he must apply with skill and with understanding. Though **The Mask** was prepared to be used in police training sessions, it points out the need for training, rather than filling that need. The educator must therefore bring along the medical knowledge to supplement the film. Its basic message to the policeman is that "concern is not weakness, but strength—strength that is more consistent with professional policing than is the defensive cynicism of the past." It jolts all of us into realizing that our so-called solutions to alcohol problems are really the least adequate response to a serious need.

McCAIN, N. C.: Approximately 100 people representing educational, treatment and rehabilitation interests in the area of alcoholism attended the spring meeting of the Alcoholism Programs of North Carolina held at North Carolina Sanitorium May 20 and 21. Appropriately, the program was focused on the duo-illnesses of alcoholism and tuberculosis. The alcoholism-tuberculosis discussion, launched by Mrs. Marty Mann, executive director of the National Council on Alcoholism, was followed up with a panel discussion in which Dr. Nicholas E. Stratas and Mrs. Lillian Pike of the N. C. Department of Mental Health and Joe Pinkston, supervisor of alcoholic rehabilitation of the N. C. Prison Department, participated. Mrs. Mann, in another presentation, urged as many local programs as could do so to affiliate with the National Council on Alcoholism as a means of strengthening and uniting the voluntary alcoholism movement in this country. Jerry McCord, director of the South Carolina Alcoholic Rehabilitation Program, later explained the advantages of individual membership in the North American Association of Alcoholism Programs, an organization of official state alcoholism programs. Both the NCA and NAAAP offer services of value to local alcoholism programs. The meeting concluded with a business session.

ITHACA, N. Y.: A program at Cornell University called "Alcoholism and Occupational Health," supported by a grant from the Smither's Foundation, is moving ahead on several fronts, according to H. M. Trice, associate professor at Cornell. Its current efforts include extension training with line managers, medical directors, personnel specialists and industrial nurses, training evaluation and study of workmen's compensation and arbitration awards as they concern employees with alcoholism and other emotional disturbances. One carefully controlled study, for instance, in which the program has invested over 200 hours of instruction in the training of 300 line management supervisors seeks to answer the question, "Does the training of line managers in handling the alcoholic employee result in early identification and referral?" Of special interest is a conference planned for July 19-21 on program implementation which seeks to answer these questions: What are some of the obstacles to an effective program? What are some of the methods of overcoming these obstacles? What are the job and organizational factors which seem to precipitate alcoholism and emotional disturbances? What preventive measures can be taken to strengthen the program? Attendance by industrial people and persons working in the field of alcoholism is invited. Interested persons may contact Mr. H. M. Trice, Cornell University, Ithaca, N. Y. 14850.

RALEIGH, N. C.: Around 500 A.A. members from all over the State joined the Central Prison A.A. Group in celebrating its 13th anniversary May 23. The third "BIG BOOK" award for outstanding service in the prison A.A. program went to Bob B. of Tryon, N. C. Woman's Prison held open house for wives.

BUTNER, N. C.: Norman A. Desrosiers, M.D., medical director of the North Carolina Alcoholic Rehabilitation Center at Butner for the past three years, has resigned to become Deputy Commissioner of Mental Health with the West Virginia Department of Mental Health, Charleston, W. Va. He assumed his new duties June 1. During his tenure as medical director of the ARC, Dr. D., as he was affectionately known to some, not only contributed wholeheartedly of himself—his talents, experience and understanding—to the patients at the center, but to the entire alcoholism control movement in North Carolina. Dr. D. had a "feeling" for the alcoholism patient and an "understanding" of the ramifications of the alcoholism problem and its effects on society, as well as ideas for solutions, which he unhesitatingly expressed the length and breadth of North Carolina. Though his contributions have been much more, he will probably best be remembered and missed, for his ability to communicate his sincerity in what he said and did. There were few, indeed, who heard him, and observed him, who failed to be convinced of the seriousness of the condition, alcoholism, and the urgency of an allout attack to combat this widespread, major health problem. Dr. Desrosiers, a native New Englander, did not "belong" to North Carolina but, after almost 20 years of his living and working here, it seemed as if he did. Prior to becoming medical director he served the mental health field in various capacities, including that of chaplain and physician, over a period of fifteen years.

Dr. "D." In Action

study, we noted that in some, usually where there was a direct request for help, the nurse was able to work well and successfully with the family. In another group of cases, however, the nurse was aware that alcohol-related problems existed, but did not attempt to deal with them. These cases represent an area in which the nurse may be missing a valuable opportunity to practice preventive medicine, by providing help before the problem becomes so acute that the patient is forced to seek out help or have it forced upon him.

About half the nurses said that they had been asked directly for help in dealing with a drinking problem and had made referrals to Alcoholics Anonymous, clinics, and to hospitals. Although more knew about Alcoholics Anonymous than about any other agency, several mentioned the fact that a successful referral depends on the nature of the patient and the situation. Most suggested that medical treatment be included, often as a readily acceptable steppingstone to getting help with emotional problems.

Concerning treatment facilities, again the nurses saw the situation as a discouraging one. "People who want to join A.A. know they have to give up liquor. There's got to be coverage for those who won't admit that they're alcoholics." "There are some fine alcoholic clinics in the city . . . but something is wrong with the structural base, because I've heard three people say, 'there were so many people in that clinic that I wouldn't stay.' " "I think the general hospitals, the emergency wards, have a lot of things they could offer that they don't.

Although it is true that treatment facilities are inadequate to the needs of the city, some of the discouragement expressed by the nurses seems due to lack of information. For example, one nurse said: "There is no clinic to which we can refer a patient who wants psychiatric care without paying a fortune." This nurse also believed that a patient who has been in a state institution is not eligible for out-patient care—a belief which is without basis in fact. Several nurses admitted that they had not been able to provide adequate information about local facilities. This is due, in part, to the rapid turnover of staff which we have mentioned. As would be expected, the supervisors were better informed than the staff nurses. However, the prevalent lack of information suggests a certain lack of interest in the problem. All district offices are supplied with literature on community resources for treatment, but few nurses indicated that they had used this material; some were not aware that it existed.

What the Nurse Does

Not unexpectedly, the nurses were unsure of what their role in treatment should be. They felt that their major function is to provide information when it is requested and, where possible, to provide motivation for treatment. One pointed out that ". . . we can't deal with the things covered by social workers, psychologists, and psychotherapists. Sometimes it's very difficult to appeal to a person to help him to seek help. And we're not equipped for this. All we can do is try to find out if he really wants help, and give him a little push." One nurse pictured her role quite clearly. "They have to depend on you and look to you for guidance. For somebody like me, who's untrained, it's a matter of gently pushing them out on their own to seek help, and to help themselves. At first it would be developing their confidence in me, get-

ting them to listen to me, and to depend on me just so far, and then setting limits and trying to push them the other way, to make them see that they have to do something for themselves." A supervisor's comment: "I'm sure the nurses don't really know where to turn, or what is the best suggestion to make. I think, too, that they probably are interested, and would like to help. If we're really going to help people, public health nurses need a lot more help in how to approach families."

If we summarize briefly the material from our interviews, we may say that the public health nurse is in a unique position to serve as an early casefinder, but that she often fails to fulfill her potential—sometimes because she does not recognize the problem, sometimes because she does not know how to handle it, and sometimes because she lacks information and interest. The majority of the nurses we interviewed were interested in alcoholism as a major public health problem but were unsure of their own role in dealing with it.

When she is specifically asked for help, the nurse often acts effectively; when not asked, she is frequently hesitant to initiate a discussion of the problem. The nurse feels that her job is to provide information and motivation, but she herself often lacks one or both. If she is to work comfortably, as well as effectively, she may also need a chance to examine her own feelings and reactions to problem drinking, so that she may better understand and deal with the feelings of others.

Recent years have brought an increasing awareness of the importance of the public health nurse's role in dealing with alcohol-related problems, in the field of public education, in providing help and support for the family of the problem drinker, and in treatment. As a result, there is a growing body of literature to which the nurse may refer, as well as conferences and seminars planned to assist her in increasing the help she is able to provide.

The interviews we have described, however, suggest the potential value of a more direct approach to training in this field, providing the opportunity for the nurse to become acquainted with community treatment resources and their personnel. A referral made without firsthand knowledge of the agency can seldom be a well thought-out plan of treatment, and may be of less than maximum benefit to the patient. Since firsthand knowledge is often impossible, a possible solution to this problem would be the preparation of a carefully annotated list of facilities, prepared by state agencies dealing with alcoholism. This list should include conditions and restrictions on admission, cost to the patient, procedures for referral, facilities and type of treatment offered, and any other information which would help the nurse to make suitable referrals.

While instruction in recognition and treatment of alcoholism and alcohol-related problems should ideally be provided as part of the basic curriculum in nursing, there is an immediate need to help those nurses who have completed their formal education and are practicing in public health. We suggest the potential value of a carefully planned inservice program aimed at helping the nurse to identify alcohol-related problems, to recognize her own feelings, and to make efficient and effective use of community treatment resources. Such programs could provide the first step toward opening up an important resource for early casefinding and prevention of one of the nation's gravest health problems.

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—Outpatient Treatment Services

‡Aftercare or Outpatient Clinics

for
(Alcoholics who have been patients of the N. C. Mental Hospital System)

—Outpatient Treatment Services

ASHEVILLE—

**Alcohol Information Center;* Mike Dechman, Educational Director; Parkway Offices; Phone: 252-8747.

†*Mental Health Center of Western North Carolina, Inc.;* 415 City Hall; Phone: ALpine 4-2311.

BURLINGTON—

**Alamance County Council on Alcoholism;* Margaret Brothers, Executive Director; Room 802, N. C. National Bank Building; Phone: 228-7053.

‡*Outpatient Clinic;* Alamance County Hospital; Hours: Wed., 9:00 a.m.-4:00 p.m.

BUTNER—

‡*Aftercare Clinic;* John Umstead Hospital; Hours: Mon.-Fri., 9:00 a.m.-4:00 p.m.

CHAPEL HILL—

†*Alcoholism Clinic of the Psychiatric Outpatient Service;* N. C. Memorial Hospital; Phone: 942-4131, Ext. 336.

**Orange County Council on Alcoholism;* Calvin Burch, Box 277, Carrboro.

CHARLOTTE—

**Charlotte Council on Alcoholism;* Rev. Joseph Kellermann, Director; 1125 E. Morehead St.; Phone: FRanklin 5-5521.

‡*Mecklenburg Aftercare Clinic;* 1200 Blythe Blvd.; Hours: Mon.-Fri., 8:00 a.m.-5:00 p.m.

†*Mental Health Center of Charlotte and Mecklenburg County, Inc.;* 1200 Blythe Blvd.; Phone: FRanklin 5-8861.

CONCORD—

†*Cabarrus County Health Department;* Phone: STate 2-4121.

DURHAM—

‡*Aftercare Clinic;* Watts Hospital; Hours: Tues. and Fri., 2:00-5:00 p.m.

**Durham Council on Alcoholism;* Mrs. Olga Davis, Executive Director; 602 Snow Bldg.; Phone: 682-5227.

FAYETTEVILLE—

†*Cumberland County Guidance Center;* Cape Fear Valley Hospital; Phone: HUdson 4-8123.

GASTONIA—

†*Gaston County Health Department;* Phone: UNiversity 4-4331.

GOLDSBORO—

‡*Outpatient Clinic;* Cherry Hospital; Hours: Tues. and Fri., 10:00 a.m.-12:00 noon. Thurs., 2:00-4:00 p.m.

**Wayne Council on Alcoholism;* H. B. Hulse, Executive Director; P. O. Box 1598.

GREENSBORO—

**Greensboro Council on Alcoholism;* Worth Williams, Executive Director; 216 W. Market St., Room 206 Irvin Arcade; Phone: 275-6471.

†*Guilford County Mental Health Center;* 300 E. Northwood St.; Phone: BRoadway 3-9426.

†*Family Service Agency;* 1301 N. Elm St.

‡*Outpatient Clinic;* 300 E. Northwood St.; Hours: Mon. and Thurs., 5:00-10:00 p.m.

GREENVILLE—

**Pitt County Alcohol Information and Service Center;* Helen J. Barrett, Director; P. O. Box 2371; 915 Dickinson Ave.; Phone: 758-4321.

†*Pitt County Mental Health Clinic;* Pitt County Health Department, P. O. Box 584; Phone: PLaza 2-7151.

HENDERSON—

**Vance County Program on Alcoholism;* Dr. J. N. Needham, Director; 2035 Raleigh Rd.; Phone: GEneva 8-4702.

HENDERSONVILLE—

Alcohol Information Center; S. Robertson Cathey, Director; 2nd Floor, City Hall; Phone OX 2-8118.

HIGH POINT—

†*Guilford County Mental Health Center;* 936 Mountlieu Ave.; Phone: 888-9929.

JAMESTOWN—

**Alcohol Education Center;* Ben Garner, Director; P. O. Box 348; Phone: 883-2794.

LAURINBURG—

**Scotland County Citizens Committee on Alcoholism;* M. L. Walters, Executive Secretary; 308 State Bank Bldg.; Phone: 276-2209.

MORGANTON—

‡*Aftercare Clinic;* Broughton Hospital; Hours: Mon.-Fri., 2:00-4:00 p.m.

NEW BERN—

**Craven County Council on Alcoholism;* Gray Wheeler, Executive Secretary; 411 Craven St., P. O. Box 1466; Phone: 637-5719.

**†Psychiatric Social Service,* Craven County Hospital; Phone: 638-5173, Ext. 294; Hours: Mon.-Fri., 9:00 a.m.-5:00 p.m.

NEWTON—

**Educational Division, Catawba County ABC Board;* Rev. R. P. Sieving, Director; 130 Pinehurst Lane; Phone: INgersoll 4-3400.

PINEHURST—

Sandhills Mental Health Clinic; Box 1098; Phone: 295-5661.

RALEIGH—

‡*Aftercare Clinic;* Dorothea Dix Hospital, S. Boylan Ave.; Phone TEmple 2-7581; Hours: Mon.-Fr., 1:00-4:00 p.m.

†*Outpatient Clinic of the Mental Health Center of Raleigh and Wake County, Inc.;* Wake Memorial Hospital; Phone 834-6484; Hours: Mon.-Fri.; 8:30 a.m.-5:30 p.m.

SALISBURY—

**Educational Division, Rowan County ABC Board;* Peter Cooper, Director P. O. Box 114; Phone: 633-1641.

†*Rowan County Mental Health Clinic;* Community Bldg., Main and Council Sts.; Phone: MElrose 3-3616.

SANFORD—

†*Mental Health Clinic of Sanford and Lee County, Inc.;* 106 W. Main St.; P. O. Box 2428; Phone: 775-4129 or 755-4130.

SHELBY—

†*Cleveland County Mental Health Clinic;* 101 Brookhill Rd.; Phone: 482-3801.

SOUTHERN PINES—

**Moore County Alcoholic Education Committee;* Rev. Martin Caldwell, Director; P. O. Box 1098; Phone: OXford 2-3171.

WADESBORO—

**Education Division, Board of Alcohol Control;* Robert M. Kendall, Director; 125 W. Wade St.; P. O. Box 29; Phone: 694-2711.

WILMINGTON—

†*Mental Health Center of Wilmington and New Hanover County;* 1013 Rankin St.; Phone: ROger 2-8294.

**New Hanover County Council on Alcoholism;* Mrs. Margaret Davis, Executive Secretary; 211 N. Second St.; Phone: 736-7732.

WILSON—

‡*Aftercare Clinic;* Encas Station; Hours: Mon.-Fri., 8:00 a.m.-5:00 p.m.

†*Wilson County Mental Health Clinic;* Encas Rural Station; Phone: 237-2239.

WINSTON-SALEM—

**†Alcoholism Program of Forsyth County;* Marshall C. Abee, Executive Director; 802 O'Hanlon Bldg., 105 W. 4th St.; Phone: PArk 5-5359.

WISE—

**Warren County Program on Alcoholism;* Rev. A. T. Ayscue, Director; Box 100; Phone: 257-4538.

YADKINVILLE—

**Alcoholism Information Center;* Rev. James A. Haliburton, Director; Yadkin County Courthouse.

EDUCATION AND INFORMATION SERVICES

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Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from the Film Library, N. C. State Board of Health, Raleigh, N. C. Please request films as far in advance as possible and state second and third choices.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—Family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

Library Books—Books on alcoholism are available from the North Carolina State Library through local libraries to residents of North Carolina. To obtain any of the books listed in the March-April, 1964 issue of **Inventory,** go to your community library and make the request.

Staff Speakers—members of the Raleigh and A.R.C. staffs are available for speeches before civic and professional groups.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the Education Division, N. C. Department of Mental Health, Raleigh.

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Education Division, N. C. Department o Mental Health
P. O. Box 9494
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